Long Term Care Institute, Inc.

Menu

LTCI-VA Survey Web Site

Department of Veterans Affairs Community Living Center Survey Report

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This document or report and the information contained herein, which resulted from the Community Living Center Unannounced Survey, has been de-identified to remove individually identifiable health information (also known as protected health information) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other federal and state laws. De-Identification was completed in accordance with guidance published by the Office for Civil Rights to protect the privacy of the Community Living Center's residents.

General Information:

Location: Manchester VA Medical Center (Manchester, NH)

Onsite or Remote: Remote

Survey Modality: Full Virtual

Dates of Survey: 4/1/2021 to 4/2/2021

Total Available Beds: 30

Census on First Day of Survey: 20

F-Tag	Findings
F604 483.10(e)(1)483.12(a)(2) *§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required*	Based on observation, interview and record review, the CLC did not ensure that a resident was free from a physical restraint that was not required to treat the resident's medical symptoms and document ongoing re-evaluation of the need for the device. Findings include: The policy dated August 2018 and titled, "SEAT BELT PROGRAM," was provided by the nurse manager on 04/02/21. The policy stated, "Residents will be evaluated on admission, quarterly, and when a change in condition is first noticed, to determine an individualized need for a seat belt. Attempts to discontinue use will be made during quarterly assessment. An assessment will be done considering the following criteria:

to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must— §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

- 1. Resident preference.
- 2. Resident ability to remove seat belt when asked.
- 3. Diagnosis to support the need for using a seat belt.

Registered Nurses:

- 1. Will be responsible for ensuring an assessment of seat belt usage is done focusing on the resident's ability to remove the device and why it is being used.
- 2. Will be responsible to evaluate the seatbelt usage quarterly and ensure it is documented in the resident plan of care."

Resident #201, [LOCATION]

- As evidenced by record review, Resident #201 was admitted to the CLC on [DATE]. The resident's history and physical (H&P) listed the resident's diagnoses as multi-infarct dementia, coronary artery disease, and history of a CVA (cerebrovascular accident).
- The resident's significant change in status Minimum Data Set (MDS) dated 08/30/20 was completed when the resident began receiving hospice care and services. According to the MDS, the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated that Resident #201 required extensive assistance with bed mobility, dressing, toilet use, and bathing; limited assistance with locomotion off the unit (outside the neighborhood); and supervision with locomotion inside the neighborhood. According to the MDS, the resident was not steady but able to stabilize without staff assistance when moving from a seated to standing position and not steady but able to stabilize with staff assistance when walking, moving on and off a toilet, and during surface-to-surface transfers. The MDS indicated the resident had functional limitations in range of motion of one upper and one lower extremity and had not had any falls. The resident's last quarterly MDS dated 02/18/21 indicated that Resident #201's cognitive status based on staff assessment continued to be severely impaired; the resident had signs and symptoms of delirium including inattention and disorganized thinking continuously, and an altered level of consciousness that fluctuated. The resident continued to need extensive assistance for bed mobility; was totally dependent on staff for transfers, dressing, toileting, personal hygiene, and bathing; was unable to walk; and required extensive assistance for locomotion in the neighborhood. The resident was not steady and only able to stabilize with staff assistance when moving from a seated to standing position, when moving on and off the toilet and during surface-to-surface transfers. The MDS indicated that Resident #201 had not had any falls.
- The resident's current plan of care addressed "Falls/Risk for Physical Restraint." A statement in the plan of care read, "I have weakness in my legs and a history of a stroke with right sided weakness, with difficulty transferring. This places me at risk for falls and I have an order for fall precautions and I am on the falling leaf program. My last fall in April of 2020…happened when I was at a different facility. I have a self-releasing alarmed lap belt on my wheelchair for my safety, but it puts me at risk for having a physical restraint." Approaches included, "I need staff to know that I am on the falling leaf program. I need nursing staff to assess me once a month to see if I still meet the requirements to be on the program. I currently have an order to be Hoyer lifted for all transfers. I need staff to know I have a self-releasing alarm lap

belt while in my wheelchair and that it needs to be checked every shift to ensure that it is in place and functioning correctly. Nursing staff also need to routinely make sure that I can self-remove the seat belt, so that it is not considered to be a physical restraint. I need staff to place a bed alarm on when I am in bed to alert staff that I am trying to get out of bed without help."

- Provider orders included an order dated 07/13/20 that stated, "Ensure vet [Veteran] wearing self-releasing alarm lap [seat] belt in wheelchair and recliner. Assure resident can self-release, check functionality q [every] shift;" and an order dated 11/06/20 that read, "Hoyer lift for all transfers."
- The interdisciplinary admission note dated [DATE] stated the following under seat belt assessment, "Seat belt Must be self-releasing seat belt." The assessment indicate the resident could release the seat belt, was not ambulatory and had an alteration in safety awareness due to cognitive decline.
- The most recent interdisciplinary quarterly assessment summary dated 02/17/21 indicated that the resident continued to have a self-releasing seat belt that the resident was able to "undue [release]." The assessment indicated the resident was "disoriented" and confused.
- During the initial tour on the morning of 04/01/21, Resident #201 was sitting in a wheelchair just outside the resident's room. When approached by staff and the surveyor, Resident #201 did not respond to questions.
- On 04/02/21, the resident assessment coordinator (RAC) liaison was asked to check if Resident #201 could release the seat belt. At 10:23 a.m. accompanied by the RAC, the nurse manager (NM) and a quality management staff person who assisted as a second liaison, the staff went to see Resident #201. When a nursing assistant asked Resident #201 to release the seat belt, the resident did not respond. The nursing assistant demonstrated how to release the seat belt, and Resident #201 looked at the nursing assistant and did not attempt to release the belt. The nursing assistant tried several times to have the resident release the belt, with no response from the resident. The nursing assistant informed the resident he would get ice cream for the resident if the resident attempted to release the belt, but Resident #201 did not respond to the nursing assistant.
- During an interview with the RAC liaison, NM and the quality management liaison at 1:05 p.m., the RAC confirmed that there had not been an assessment by a registered nurse according to the CLC's policy for the use of the seat belt. The RAC indicated the resident had "never had any falls here [the CLC]." The RAC confirmed that the falling leaf notes did not address the seat belt and the NM stated, "I should admit that it [falling leaf notes] should address that [seat belt]." The RAC confirmed that the provider did not order the seat belt until 07/13/20, but that it had been in use since [DATE] when the resident was first admitted to the CLC. When asked what alternatives had been attempted before the seat belt was implemented, the NM and the RAC indicated that "nothing else" was implemented by staff. The NM stated, "It sounds like I need to adjust my nursing assessments. We know what you're getting at." The NM stated, "[The nursing assistant who tried to get the resident to release the lap belt] tried to bribe [the resident] with ice cream and everything. If anybody could get him [Resident #201] to do that it would have been [the nursing assistant]." When asked why the last quarterly interdisciplinary assessment indicated that Resident #201 could release the seat belt, the NM and RAC confirmed that the resident could "probably physically release the lap belt but would not understand" how to do so. The

NM indicated that the resident "used to release it [the seat belt] when he was first admitted [to the CLC]." The NM stated the resident had not been observed releasing the seat belt recently.

- In summary, Resident #201 had been using an alarmed seat belt since admission on [DATE]; the seat belt was ordered for use by a provider on 07/13/21. Assessments completed after admission indicated the resident could independently release the seat belt. The assessments did not address a medical symptom for which the seat belt was to be used. Staff indicated less restrictive alternatives had not been attempted prior to use of the device. During the survey, the resident was not able to independently release the seat belt. The resident's plan of care stated, "Nursing staff also need to routinely make sure that I can self-remove the seat belt so that it is not considered to be a restraint."

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483.25 *§483.25 Quality of care. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure that a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered plan, and the resident's choices. Findings include:

On 04/02/21, the nurse manager provided a copy of the Manchester VA Medical Center SOP (Standard Operating Procedure) 18-16 dated November 2018 and titled, "WOUND CARE ASSESSMENTS ON THE COMMUNITY LIVING CENTER & PALLIATIVE CARE UNIT." Based on the SOP, "The wound care nurse and/or RN will conduct weekly rounds (Wednesday) on all residents with known wounds, pressure ulcers, and high-risk residents…the wound care nurse/RN will be responsible for ongoing wound assessment and reassessment…will ensure that prevention measures and interventions are documented in the resident's plan of care and weekly skin inspections and that staff, resident and/or caregivers are educated on these measures and interventions…."

Resident #103, [LOCATION]

- As determined through clinical record review, Resident #103 was admitted to the CLC on [DATE] with diagnoses that included chronic osteomyelitis, chronic pain syndrome, and congestive heart failure (CHF). Other medical conditions included right below knee amputation (BKA), chronic osteomyelitis, neuropathy, cerebrovascular accident (CVA), and diabetes mellitus type 2.
- The resident's significant change in status Minimum Data Set (MDS) dated 12/24/20 was coded to indicate Resident #103 had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition. The MDS indicated the resident rejected care daily, required supervision with most activities of daily living (ADLs) including transfers, was independent with bed mobility, and personal hygiene, had functional limitations in range of motion of the lower extremity on one side, and used a walker and wheelchair for mobility. Section M (Skin Conditions) of the MDS indicated the resident had two venous and arterial ulcers, other open lesions on the foot, and surgical wounds. Skin and ulcer/injury treatments included surgical wound care, application of nonsurgical dressings (with or without topical medications) other than to the feet, applications of ointments/medications other than to the feet, and application of dressings to the feet (with or without topical medications).
- The resident's most recent quarterly MDS dated 03/25/21 indicated Resident #103 had a BIMS score of 15 suggesting intact cognition; did not reject care; was independent with all ADL care including bed mobility, transfers, and toilet use; had functional limitations in range of motion of one lower extremity; and used a wheelchair for mobility. Section M (Skin Conditions) of the MDS indicated the resident had one venous and arterial ulcer, other open

lesions on the foot, and surgical wounds. Skin and ulcer/injury treatments included a pressure reducing device for the chair and bed, surgical wound care, application of nonsurgical dressings (with or without topical medications) other than to the feet, applications of ointments/medications other than to the feet, and application of dressings to the feet (with or without topical medications). A turning and repositioning program and nutrition and hydration intervention to manage skin problems were not checked as treatments.

- A statement in the resident's current care plan dated 05/20/20 with a review date of 11/12/20 read, "I am weak, and I have limited endurance. My right leg is amputated below the knee. I often believe I can do more for myself than I should. I refuse to let staff assist me with bathing and dressing, as I do not like to be touched by others….I have venous insufficiency, fragile skin because of medications that I take, I… sometimes hit my [left] leg against my bed side rails or side of my wheelchair. This causes wounds and bruises that come and go on my left leg/foot. I often refuse assistance to change my dressings." One of the care plan goals stated, "My skin treatments will be performed as ordered for the next 90 days…I will let staff teach me and encourage me to use proper hygiene when I'm doing dressing changes on my wounds for the next 90 days." Care plan interventions related to prevention and/or treatment of wounds on the left lower extremity indicated that nursing staff were to remind the resident to elevate his left leg while in bed, assess the resident's skin weekly as ordered due to refusal to allow nursing staff to check his skin three times a week, inform the provider of any abnormal finding noted during the skin assessment, and remind the resident as needed to frequently change position especially when seated in a wheelchair. The interventions indicated the resident preferred to apply all ordered skin creams and do his own wound dressing changes; nursing staff were to offer to change the dressings/perform skin treatments and document any refusal or watch the resident perform dressing changes, provide the resident with wound care supplies, treat the vascular ulcer on the left anterior foot with anasept cleanser, soak gauze with anasept cleanser and let it sit for three to five minutes then apply cadoxemer iodine and cover with optifoam daily and as needed. Nursing staff were to encourage the use of tubigrip compression for the resident's left lower extremity edema as the resident might refuse the tubigrip, place the tubigrip on in the morning and remove it in the evening; and apply absorbase cream to the resident's left lower extremity daily and as needed.
- Another statement in the plan of care dated 03/04/21 indicated Resident #103 "uses bed rails to assist with medical symptoms: [blank]. The care plan goal stated the resident would "not sustain any injury from having bedrails…." The care plan approaches included but were not limited to staff assessing the resident on admission, quarterly and with any significant changes [for] identification of any injuries or potential injuries that occurred during use of bedrails…."
- The current provider order sheet included the following:
  - "02/23/18 elevate leg while in bed."
  - "03/03/21 Change CADEXOMER IDIODINE GEL, TOP [topical] 0.9% SMALL AMOUNT TOP DAILY open areas on LLE [left lower extremity]: cleanse with anasept cleanser, apply small amt [amount] Cadexomer gel, cover with hydrophilic foam and warp with kerlex. Vascular ulcer."
  - "03/04/21 Change Furosemide tab [tablet] 40 mg [milligrams] PO [orally] SU-MO-TU-WE-TH-FRI-SA [every day] @ 1000-2100 [at 10:00 a.m. and 8:00 p.m.] CHF [congestive heart failure] to Furosemide tab 80 mg PO SU-MO-TU-WE-TH-FRI-SA @ 1000 CHF."
  - "03/10/21 Change open areas on LLE [left lower extremity]: cleanse with anasept cleanser, apply small amt [amount] Cadexomer gel, cover with hydrophilic foam and wrap with kerlex daily at bedtime per his [the resident's] request to open areas on LLE: cleanse with anasept cleanser, apply small amount Cadexomer gel, cover with optifoam daily at bedtime per his request, document refusal."

- On 04/02/21 wound notes were reviewed. The wound notes documented by the RN wound nurse on 02/03/21 indicated Resident #103 allowed the RN wound nurse to change his dressing and there were no significant changes in the resident's wounds which included "vascular ulcer to dorsal foot measures 2 [cm] L x 1.3 [cm] W x 0.2 [cm] D with a beefy wound bed and mild erythema around periwound." According to the wound notes of 02/03/21, there were "small areas of moisture damage as well, but no indication of infection. There is another open area to the shin which also looks clean and measures 3.2 [cm] L x 1.2 [cm] W x 0.1 [cm] D and open area to posterior lower leg measuring 1.0 [cm] L x 1.0 [cm] W x 0.1 [cm] D. He has edema to LLE, and all areas are weeping moderate to large amount of drainage. He refuses compression to LLE…he wants to try triad paste today to all open areas…."
- The wound notes documented by the RN wound nurse on 02/12/21 stated the resident "currently has one open area to shin measuring 3.5 [cm] L x 1 [cm] W x < [less than] 0.1 [cm] D, wound base looks clean and beefy red. Vascular ulcer to dorsal foot measures 1.5 [cm] L x 1.3 [cm] W x 0.1 [cm] D. Open area to posterior lower calf measures 1 [cm] L x 2 [cm] W x <0.1 [cm] D. He continues to refuse compression to LLE."
- The wound notes documented by the nurse practitioner on 02/17/21 indicated Resident #103 had the following wounds on the left lower extremity:
    - "Vascular ulcer on the left leg shin, proximal, 3.0 cm length, 0.5 cm width, <0.2 cm depth, pale pink non-epithelialization tissue, moderate serosanguineous exudate, with maceration on the surrounding tissue." (This was the first documentation regarding the left shin proximal wound, as confirmed by the ANM).
    - "Vascular ulcer on left shin, distal, 3.0 cm length, 1.1 cm width, <0.2 cm depth, pale pink non-epithelialization tissue, moderate serosanguineous exudate, with maceration on the surrounding tissue."
    - "Vascular ulcer on the left dorsal foot, proximal, 1.5 cm length, 1.4 cm width, <0.2 cm depth, epithelialization (pink tissue), moderate serosanguineous exudate, with maceration on the surrounding tissue."
    - "Vascular ulcer on the left dorsal foot, distal, 0.6 cm length, 1.0 cm width, <0.2 cm depth, pale pink non-epithelialization tissue, moderate serosanguineous exudate, with maceration on the surrounding tissue." (This was the first documentation regarding the distal wound as confirmed by the ANM).
    - "Vascular ulcer on the left posterior lower calf, 1.2 cm length, 1.0 cm width, <0.2 cm depth, epithelialization (pink tissue), moderate serosanguineous exudate, with maceration on the surrounding tissue."
- The wound notes indicated new or changed provider orders as follows: "open areas to LLE shin distal wound and dorsal foot proximal wound – cleanse with N/S [normal saline], apply opticell AG to wound bed, cover with optifoam daily and PRN [as needed]. Open areas to LLE proximal shin, distal dorsal foot, posterior lower calf – cleanse with N/S [normal saline], apply triad paste and cover with optifoam BID [twice daily]."
- The wound notes documented by the nurse practitioner on 02/24/21 indicated Resident #103 "refused the skin check." An order stated, "Ordered interventions for the open areas to LLE shin distal wound and dorsal foot proximal wound: cleanse with N/S, apply opticell AG to wound bed, cover with optifoam daily and PRN; open areas to LLE proximal shin, distal dorsal foot, posterior lower calf cleanse with NS; apply triad paste and cover with optifoam BID."
- A weekly skin inspection note completed by a licensed nurse on 03/01/21 documented Resident #103 had two-plus pitting edema on his LLE and open areas (other than the wound measurement and anatomic location, there was no additional information related to the wound characteristics) as follows:
    - "Anterior shin [#1] 3.0 cm x 2.0 cm x 0.1 cm"
    - "Medial shin [#1] 1.0 cm x 1.0 cm x 0.1 cm"

    - "Anterior shin [#2] 4.0 cm x 2.0 cm x 0.1 cm"
    - "Medial shin [#2] 3.0 cm x 1.5 cm x 0.1 cm"
    - "Anterior shin [#3] 1.0 cm x 1.0 cm x 0.1 cm"
    - "Anterior shin [#4] 1.0 cm x 0.5 cm x 0.1 cm"
    - "Anterior shin [#5] 1.0 cm x 1.0 cm x 0.1 cm"
    - "Left foot dorsal 2.0 cm x 1.5 cm x 0.1 cm"
    - "Left foot dorsal 2.0 cm x 3.0 cm x 0.1 cm"
- The wound notes documented by the RN wound nurse on 03/02/21 stated Resident #103 "has multiple open areas to LLE; several vascular ulcers and few abrasions which come and go. They are located on the shin, calf, dorsal and lateral foot, and ankle. Vet reports he bangs his leg and foot on things during the night a times when OOB [out of bed] to use the bathroom. He refuses assistance from staff and does not wish for his door to be opened by staff or to be disturbed if his door is closed. He continues to have edema to the leg and foot and reports heavy drainage at times. He refuses compression. The wounds are not weeping upon assessment today…orders changed to Cadexomer, hydrophilic foam, and kling wrap…." There was no additional information in the note regarding causal and contributing factories to the open areas.
- Wound notes documented by the RN wound nurse on 03/12/21 stated Resident #103 "has multiple open areas to LLE; several vascular ulcers and few abrasions which come and go. They are located on the shin, calf, dorsal and lateral foot, and ankle. He has 2 vascular ulcers to the dorsum of his foot. The distal one measures 1.3 [cm] L x 2.3 [cm] W; it is shallow with yellow slough to the wound bed. Vet stated he has been leaving it open to air. He was educated to follow treatment as ordered and that a healthy wound bed should not be yellow. He verbalized understanding. The proximal ulcer measures 1.2 [cm] L x 1.5 [cm] W; the wound bed is cleaner with minimal slough; both appear to be shallow at approximately 0.1 [cm] D…continue the following: open areas LLE: cleanser with anasept cleanser, apply a small amount of Cadexomer gel, cover with optifoam daily at bedtime at his request, document refusal…"
- Wound notes documented by the RN wound nurse on 03/15/21 stated the resident reported that he "found a new open area on the bottom of my [his] foot" and the resident "did not recall hitting it on anything although he has neuropathy." According to the wound notes of 03/15/21, the open area to the mid-plantar foot had "bloody drainage and area measured approximately 1.0 cm x 1.0 cm x <0.1 cm [less than 0.1 cm in depth], slightly irregular in shape and does not appear to be pressure related. The wound notes further documented the resident had "6 [six] open areas to the shin, 2 open areas to the calf, 2 to the dorsum of the foot…." There was no additional information indicating that further review had been conducted including environmental surveillance to determine how the resident could have injured his foot. There was no additional information indicating use of appropriate footwear was reviewed to prevent further injuries.
- The wound notes documented by the RN wound nurse on 03/23/21 stated, "Improvement is noted to size of open areas to calf and shin. Lasix dose was increased on 3/5 [03/05/21]; veteran continues to refuse the compression. No significant edema noted on this date…he continues to have an open area to the plantar aspect of foot which is approx. [approximately] 1 cm L x 3.0 cm W which is largely superficial but with center area of 0.5 [cm] x 0.3 [cm] slightly deeper with white fibrinous wound bed…continue the following: open areas LLE: cleanse with anasept cleanser, apply a small amount of Cadexomer gel, cover with optifoam daily at bedtime at his request, document refusal…."
- The most recent wound note dated 03/31/21 documented Resident #103 had "vascular wounds to dorsal foot [distal and proximal] and an open area to the plantar aspect of foot with small amount of drainage and is now 0.5 cm [centimeters] L [length] x[by] 0.5 cm W [width] x 0.1 cm D [depth]." The wound notes further stated the resident had "a new abrasion" to his left shin that measured approximately 1.0 centimeter (cm) in length, 1.0 cm

in width, and 0.2 cm in diameter with the wound bed “partially obsured [obscured] by blood and triad paste” that the resident said he applied. When interviewed by the RN wound nurse about the new abrasion, the resident reportedly said, “I banged it [my shin] on something during the night.”

- During an initial interview with the assistant nurse manager (ANM) on 04/01/21 at approximately 9:57 a.m., the ANM reported the resident’s primary concern was left foot pain. Further interview with the ANM at 11:00 a.m. indicated Resident #103 “was previously on hospice care but was discharged [10/07/20] and then decided again to be on hospice [12/08/20] because of chronic osteomyelitis, stayed in his room, opened his door around 10:30 a.m. to receive his medications, and kept his door closed unless he was ready to receive his meals.”
- Resident #103 was interviewed in his room on 04/01/21 at approximately 11:16 a.m. At the time of the interview, the resident was seated in his wheelchair next to his bed. During the interview, the resident stated, “I just took pain medication an hour ago for [his] left foot pain.” When asked about his left foot (the resident’s left lower extremity was not visualized during the interview), the resident said, “I broke my foot and ankle about six years ago and have had issues with it. I cannot wear my prosthetic leg because of the issues on my foot.”
- On 04/01/21 at approximately 4:10 p.m., during a preliminary review of the resident’s clinical record and an interview with the ANM about the resident’s wound care, the ANM stated the resident “was very particular about his wound care, preferred to do his own dressing changes, and did not allow staff to do his dressing changes.” Although a request was made to observe the resident’s dressing changes, it was indicated the resident changed the dressing in the evening. The ANM stated the resident’s provider was aware the resident did his own treatment. Review of the most recent wound notes on 03/31/21 indicated the resident had “vascular wounds to dorsal foot [distal and proximal], an open area to the left plantar aspect of foot and a new abrasion” to his left shin. The ANM indicated that the resident said, “[I] banged it [the shin] on something during the night.” Review of the wound nurse note dated 03/15/21 documented the resident reported that he “found a new open area on the bottom of my [his] foot” and the resident “did not recall hitting it on anything….” At 4:20 p.m. during an interview, the RN wound nurse who authored the wound notes on 03/15/21 and 03/31/21 stated the resident “probably hit his foot and may not realize it because of neuropathy.” The RN wound nurse added, “I do not think the wound on the bottom of his foot was pressure related; he must have stepped on something and did not realize it until he saw the blood. The one [wound] on his left shin; he said he hit his leg against something during the night. He does not like to use any night light or to keep the bathroom light on. He may be hitting his leg against the bathroom door and because he has neuropathy, he does not feel it.” The RN wound nurse said, “….he did report hitting his leg against the side of his wheelchair.” When asked if modifications to the resident’s environment had been made to prevent accidental injuries to the resident’s left lower extremity, the RN wound nurse and ANM said, “We can probably approach him and talk to him about padding his wheelchair or his door.” The RN wound nurse was not able to confirm if the resident wore any footwear on his left foot.
- On 04/02/21 at 8:00 a.m. during an interview, the ANM stated the evening shift RN interviewed Resident #103 on 04/01/21 about the injuries on his left lower extremity and discussed environmental modifications such as applying some type of padding on the doorframe. The ANM further stated that based on the report by the evening shift RN, Resident #103 “denied hitting his left leg on the door and said he had a scab on his leg and pulled on the skin.” The ANM remarked, “We go by whatever he reports to us. Last night, he said he was picking his skin and that is not unusual for him.”
- On 04/02/21 at approximately 10:02 a.m., the surveyor interviewed the ANM and the RN wound nurse about ongoing monitoring and assessment of Resident #103’s vascular ulcers and other injuries as stated in the CLC policy on wound care assessments. The staff were

asked if the interdisciplinary team had considered further evaluation of the resident's risk factors to development of the vascular ulcers and other injuries such as environmental hazards (e.g., wheelchair, bathroom door) and determined the effectiveness of the resident's care plan approaches to remove, modify, or stabilize the risk factors. The RN wound nurse said, "His ulcers come and go, and it would help if he wore the compression [tubigrip]. We have so many time constraints and he does not allow just anyone to do his dressing changes. He has lots of ulcers; typically, if he has multiple ulcers, I will describe the largest ulcer." When asked if the RN wound nurse had considered coordinating with the licensed nurses with whom the resident had allowed to do the weekly skin assessments, the ANM stated, "That is probably something we can do moving forward. Certain nurses are agreeable to him and we can set up a plan to do the wound assessment and follow-up on what he reports to us [investigate the cause of the injury to the resident's LLE]."

- On 04/02/21 at approximately 1:00 p.m. during an interview, the ANM stated, "I have talked to the therapist and asked them to assess the wheelchair. The therapist suggested protecting the lower area of the wheelchair with some form of a sleeve and it is already being purchased. Moving forward, we will review his care plan and address the trauma, environment, and behavior component to him getting the ulcers."
- In summary, Resident #103 had multiple chronic vascular ulcers to the LLE that were caused by various factors to include the resident's edema and refusal to wear the compression tubigrip, and the resident hitting his LLE on the side of the wheelchair. The CLC did not consistently conduct monitoring and assessment of the resident's vascular ulcers and other injuries as indicated in the CLC's policy. The CLC did not conduct further evaluation of possible causal and contributing factors to development of the resident's vascular ulcers and other injuries such as environmental hazards (e.g., wheelchair, bathroom door) and identify approaches (e.g., padding of the wheelchair, use of footwear) to address the causal factors. The CLC did not determine the effectiveness of the resident's care plan to remove, modify, or stabilize the factors.

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